Clinical risk management
Learning from death

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Abstract

Reporting a death to the coroner by a doctor is not a statutory duty. It is, however, expected good practice. This article discusses some of the concerns arising out of current everyday practice that can lead to problems for doctors and their employing organisations. The author considers the importance of risk management, clinical audit and clinical governance in identifying what systems may need to be addressed within hospital and primary care trusts to ensure that deaths arising out of, or occurring during, medical care are investigated appropriately. As part of risk management and controls assurance, NHS Trusts should be able to demonstrate that lessons are learnt from adverse outcomes. This article explores the roles of postgraduate tutors, risk managers and the protection organisations in promoting good practice from the start of a doctor's career.

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Introduction

Every day deaths occurring within hospitals or in the community are reported to the coroner. What used to be a process that attracted little media attention has assumed an importance that has sadly sinister connotations. The reasons for this include the Shipman case, the "organ scandals" and the public questioning of the competence of doctors whose acts or omissions may have led to the death of a patient. The role of the pathologist has come under scrutiny as have the roles and responsibilities of the doctors involved in either notifying the coroner or certifying death in circumstances that do not appear to require the coroner's involvement.

There are a number of aspects of these various processes that can be and should be considered under the umbrellas of clinical governance and clinical risk management. These include training and supervision, untoward incident reporting and continuing education. The information gleaned from the processes involved in a coroner's inquest can be usefully applied to health service professionals to develop knowledge bases, prevent recurrence of problems (if a problem has been identified), form the basis of clinical audit and give opportunities for evaluation of clinical decision-making and practice.

Referral to the coroner

Under present law, there is no statutory requirement for a doctor to report any death to the coroner, but doctors are encouraged as a matter of good practice to inform the coroner of deaths in circumstances that require an inquest.

In the last few years, members of the medical profession have been sent circulars giving them general advice about death certification (Coleman, 1996) and that emphasise the importance of passing on all relevant information to coroners when reporting deaths (CMO, 1998). Information about reportable deaths should also be readily available in hospitals and general practice, but whether this is consulted often enough is debatable.

The protection organisations are contacted on a fairly frequent basis for advice and information in relation to inquests. The questions can be wide ranging and, on

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occasions, demonstrate a considerable lack of knowledge of the functions of the coroner and the requirements placed on medical practitioners in terms of reporting deaths.

There is an excellent text that should be available within all postgraduate libraries that clearly sets out the role of the coroner, the reporting requirements and background to the coroner's court. It demystifies a great deal and explains the historical background and relevant law that governs our current system. The book, *Coroner's Courts: A Guide to Law and Practice* (Dorries, 1999) provides clear guidance as to medical responsibilities, preparing reports, appearing in court and how verdicts are reached.

The junior doctor

Death certification

The ability of junior doctors to fill in death certificates properly and the ability of doctors to recognise reportable deaths has been questioned in the literature on a number of occasions. In an article supporting greater involvement of the coroner in the investigation of deaths, Leadbetter and James (1999) proposed an alternative solution. They suggested that all deaths occurring during clinical care should be reported to the coroner once an assessment has been made by the consultant or GP in charge had assessed the case in consultation with an independent consultant such as a pathologist or specialist in public health medicine with an interest in the accuracy of mortality statistics. The paper details how this may be achieved and how the process will "inform and support the current political, professional and public desire for clinical governance".

We are currently a long way from this process, but need to ensure in the meantime that certification and reporting to the coroner is robust. The above model quoted guarantees consultant involvement within hospitals and gives greater consideration (and maybe credibility) to the accuracy and validity of certification. We know there can be a problem with some junior staff who are in many ways, wrongly, required to discuss cases with the coroner and may not always fill in certificates appropriately if the coroner is not involved.

Responsibilities and training

The GMC in its booklet, *The New Doctor* (General Medical Council, 1997, para. 18) suggests that, to fulfil the aims of general clinical training, induction training should include topics such as management of the dying patient, coping with bereavement, death certificates and reports to the coroner/procurator fiscal.

The booklet also recommends the use of house officers' handbooks that summarise information needed by PRHOs (General Medical Council, 1997, para. 20). The topics suggested do not, however, include information about death certification or deaths that are reportable to the coroner. From a risk-management and good-practice perspective, this information should ideally be contained within an induction handbook. Where MPS has undertaken reviews of induction material for trusts for risk assessment purposes the absence of this information has been highlighted. Valuable opportunities for teaching and discussion may be lost at this early stage.

The role of the postgraduate tutor

The postgraduate clinical tutor has specific duties to fulfil in ensuring that new doctors have appropriate induction programmes and that their educational supervision meets the standards set by the GMC. It is expected that this be undertaken by appropriate liaison with educational supervisors and other medical and non-medical staff involved in training and support of the PRHOs. It should follow that the advice provided to junior doctors in the event of a death being reported to the coroner and an inquest opening is consistent and accords with good practice.

Following discussions with many junior doctors during and after teaching sessions dealing with medico-legal issues, it is the writer's experience that a very rudimentary knowledge of these matters is the norm. Within the first few months many PRHOs have been involved in reporting deaths to the coroner without the requisite knowledge of the system and how the death is likely to be further investigated.

All too often junior doctors can be left to seek their own independent professional advice when NHS Trusts should be providing support and advice through their own organisation. By allowing this situation to continue the opportunity for audit and

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analysis of cases reported to the coroner is lost, as individuals understandably worry more about their own potential professional predicament than the lessons to be learnt.

The risk/claims manager and the coroner

The role of risk and claims managers in inquests has perhaps not been as well developed as it should. Clinicians, particularly at junior level, who are often not even aware of the existence of such an individual within a Trust, may not consider involving them in the work that is required to prepare for an inquest.

The responsibility placed upon risk and claims managers in fulfilling their roles makes it essential to tell them about deaths reported to the coroner as early as possible.

The revised Clinical Negligence Scheme for Trusts (CNST) risk management standards (CNST, 2000) require a number of checks and assessments to be undertaken to ensure that clinical risk assessment is a key component of clinical governance. The same is true of Controls Assurance (Controls Assurance Team, 1999). In the advice CNST provides to trusts on conducting a trust-wide assessment, it offers suggestions for ensuring that all areas are addressed, for example "those risks that could lead to death, disability or severe distress to the patient" (CNST, 2000, p. 126) – this surely must include analysis of deaths that have been reported to the coroner.

In establishing whether the trust has met this standard, the CNST assessors look for evidence of trust-wide communication of clinical issues. They question whether there are "systems in place for learning from past experience utilising internal information from audit, complaints, incident reporting, claims and external data from national reports such as CESDI and CEPOD" (CNST, 2000, p. 128). It is self-evident that pathologists and clinicians will have information regarding deaths that have occurred during medical care, and that collecting and analysing these data could lead to future risk reduction.

If reportable deaths are to be considered part of the trust's risk-management process (if only to confirm that the care was appropriate and the death inevitable), then one can find other references within the CNST standards that can be applied to reportable deaths and inquests. These include staff induction, consent, documentation, training and supervision, use of equipment, competence etc. In essence, the Trusts have a valuable tool, but is it applied appropriately and linked effectively?

Claims and complaints arising from deaths reported to the coroner

Not all relatives are satisfied that the death of a loved one was inevitable. Every year, complaints and claims handlers within Trusts are faced with the difficult task of dealing with bereaved and distressed relatives who remain unconvinced that health care has been straightforward. Even if the family understands the severity of the last illness, the nature of the injuries and pre-existing condition, the prospect of an inquest can be alarming. If one adds to this some doubts about the clinical management (such as the appropriateness or timeliness of the medical interventions) there is a recipe for potential conflict between several parties – the bereaved, the health professional and the employer.

In-depth review of those cases that are of potential concern is necessary and may bring a great deal to the surface that should be addressed within any healthcare organisation. This may include general practice care and possibly local authority involvement. Timely and sensitive investigation as preparation for the inquest can be invaluable.

The role of clinical audit

All health professionals are directly or indirectly involved in clinical audit, none more so than hospital clinicians. Good medical practice, in its broadest sense, requires clinicians to participate in clinical audit and this will in most specialties necessarily include review of clinical cases that have resulted in an unexpected outcome – namely death in the context of this article. The Royal College of Anaesthetists in conjunction with the Association of Anaesthetists of Great Britain and Ireland (1998), for example, is keen to develop the quality of clinical audit particularly in respect of critical incident reporting and regular reviews of deaths.

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The National Confidential Enquiry into Perioperative Deaths (NCEPOD) reports tend to reinforce the need to learn from data collected for the purposes of the Enquiries. There is always reference to low post-mortem rates and the benefits of attending post-mortem examinations. Whilst recent national events may well affect the numbers of relatives who give consent for post-mortems, there will still be a requirement for coroner's post-mortems to establish a cause of death in certain cases. It is important that consideration is given to the comments made in the report into Extremes of Age which stated "Systems need to be established to ensure that clinicians always receive copies of coroner's or hospital post mortem reports" (NCEPOD, 1999).

The doctor, the coroner and the protection organisations

A review of MPS's database demonstrates that, between 1996 and 2000, members made over 1,000 separate written requests for information or advice in relation to inquests. These were in addition to countless requests for telephone advice.

The enquiries came from GPs and hospital doctors of all grades. In many cases, assistance with report writing was requested and in others greater support was necessary due to professional criticism or potential conflicts arising. Many of the cases were relatively straightforward and advice was limited to general support of the doctor's role and guidance in formulating a report. In others the clinical facts were of more concern.

There were several cases where a thorough analysis should have been (and hopefully was) undertaken at the hospital where the death occurred and risk-management initiatives taken to prevent a recurrence. A number of these cases will have been or are being pursued through the courts, with little possibility of a defence.

Figure 1 shows data from 117 cases picked at random. A significant number of patients appear to have committed suicide (29 per cent). All such cases should be fully investigated as a matter of course; concerns should be raised if it appears that inadequate risk assessments of the patient had been undertaken, inadequate supervision had been provided or there had been diagnostic errors relating to the psychiatric illness. Close scrutiny of the care provided for those patients who have committed suicide on health service premises is to be expected. Whilst often a conclusion may be reached that all was done that could have been done, it is essential for individual practitioners and members of the mental health team to satisfy themselves that this is indeed the case.

A number of factors may be implicated in deaths reported to the coroner which initially do not cause undue alarm to those involved in the provision of care. Further analysis may reveal deficiencies, which, whilst not necessarily responsible for the death may have contributed to it. For example, of the patients who died of severe injuries following road traffic accidents (7 per cent) in this series, undiagnosed injuries led to subsequent problems such as an intrathoracic bleed (two cases).

Other patients who were seriously ill were further compromised by problems with resuscitation attempts, including using the wrong drugs, incorrect positioning of the endotracheal tube and, in one case, perforation of the aorta during a tracheostomy.

Some of the procedural problems that occurred in this series and makes alarming reading:

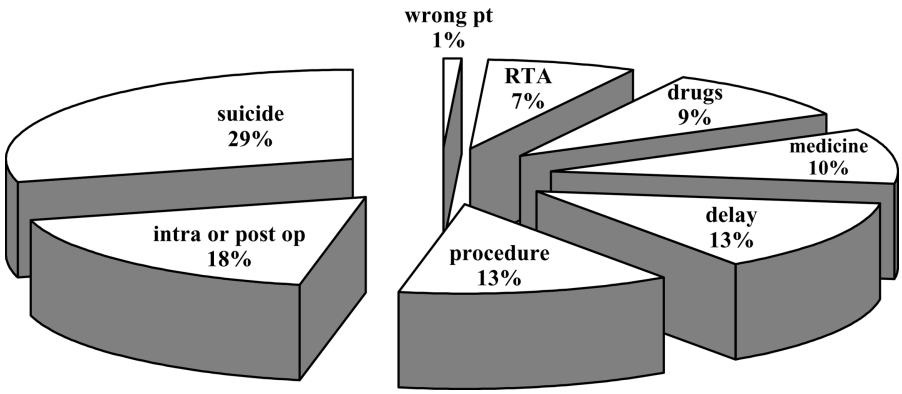
- epidural;
- tracheostomy;
- pleural tap;
- venous catheters;
- angiogram;
- laryngoscopy; and
- intubation problems.

Whilst it is generally accepted that all procedures have recognised complication rates (for example endoscopic procedures), failure or delay in recognising the presence of a complication such as a perforated viscus or punctured vessel (is not usually acceptable. Risk-management lessons could be learnt from most of these cases if they were studied further.

The following outlines some of the prescription errors that have occurred in this small series:

- wrong doing;
- wrong route;
- side-effects; and
- monitoring.

Figure 1 Series of 117 written enquiries to MPS regarding inquests: factors implicated in the patient's death



It is no different from any list of common prescription errors (most of which do not, fortunately, result in the patient's death). What distinguishes this list is that each error is included in the series because there was a fatal outcome. Examples such as the prescription of excessive doses of amiodarone in one case, midazolam in another and in a third, the failure to monitor warfarin leading to a catastrophic bleed were probably the main factors in the deaths, whereas in other cases drug errors no doubt contributed to an already complex clinical situation. Proper investigation of these and similar cases is essential if systems are to be improved.

Conclusion

It is apparent from the above that we cannot afford to be complacent about the current situation regarding notification of deaths to the coroner. Irrespective of recent high profile cases, the day-to-day processes should perhaps be reappraised as a risk-assessment exercise. In particular, consideration should be given to:

- Reviewing junior doctors' education on death certification and the coroner's role. Provision of induction material that has basic information about which deaths should be reported and how the process works would be beneficial in some organisations. GP trainers may consider that similar material is required for GP registrars.
- Objective clinical involvement in the management and investigation of deaths within a healthcare setting, together with a more structured and supportive co-ordination of witnesses and preparation of reports.

Encouraging medical and nursing staff to accept that unexpected deaths need to be looked at carefully without necessarily threatening them professionally is important. The roles of clinical audit and clinical-risk managers in helping to identify areas of potential weakness should also be acknowledged. Even in those cases where death was an expected outcome it is not unreasonable to consider whether there were any aspects of the last illness that could have been improved. This includes assessing the standard of clinical note keeping – the sooner some doctors stop writing RIP and drawing a tombstone and flowers in the notes the better.

References

Chief Medical Officer (1998), *CMO's Update*, No. 20.
CNST (2000), *Clinical Risk Management Standards*, NHSLA, London.
Coleman, M.P. (1996), "Death certification and referral to the coroner", letter from the Office for National Statistics.
Controls Assurance Team (1999), *Guidelines for Implementing Controls Assurance in the NHS: Guidance for Directors*, NHSE, Leeds.
Dorries, C.P. (1999), *Coroner's Courts: A Guide to Law and Practice*, John Wiley, Chichester.
General Medical Council (1997), *The New Doctor*, GMC, London.
Leadbetter, S. and James, R. (1999), "Clinical governance and the coroner" , *J.R. Coll Physicians*, Vol. 33, pp. 451-3.
NCEPOD (1999), *Extremes of Age, National Confidential Enquiry into Perioperative Deaths*, London.
Royal College of Anaesthetists and Association of Anaesthetists of Great Britain and Ireland (1998), *Good Practice: A Guide for Departments of Anaesthesia*, RCA, London.